STATE OF MAINE

BOARD OF
RESPIRATORY CARE PRACTITIONERS

APPLICATION FOR LICENSURE

- RESPIRATORY CARE THERAPIST
- RESPIRATORY CARE TECHNICIAN
- TEMPORARY RESPIRATORY CARE TECHNICIAN
- RESPIRATORY CARE TRAINEE

Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8579
TTY/HEARING IMPAIRED (207) 624-8563 FAX #: (207) 624-8637
Office located at: 122 Northern Avenue, Gardiner, Maine
E-Mail: cathleen.a.bitz@maine.gov

Printed under appropriation 01402A42600012 Revised 04/05
Physical Location: 122 Northern Ave., Gardiner, ME 04345
Website: www.maineprofessionalreg.org

APPLICATION INSTRUCTIONS

The Board of Respiratory Care Practitioners requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be $15.00 as of May 1, 2003.

Listed below are the requirements for licensure as a Respiratory Care Practitioner in Maine. This is provided for informational purposes only.

FOR: THERAPISTS AND TECHNICIANS

- ☐ Application fee: $50.00
- ☐ License fee: $135.00, ($67.50 after May 1st of odd numbered years)
- ☐ Criminal background record check $15.00
- ☐ Two completed reference forms (Attachment "B")
- ☐ Verification of licensure from every state that you hold or have ever held a license. (Attachment "C")
- ☐ Written confirmation of applicant's credential from the NBRC. You can reach the NBRC at: 8310 Nieman Road, Lenexa, KS 66214-1579, Telephone # (913) 599-4200. You need to inform the NBRC to send the verification to you.

FOR: TEMPORARY TECHNICIANS

- ☐ Application fee: $50.00
- ☐ License fee: $25.00
- ☐ Criminal background record check $15.00
- ☐ Completed reference form (Attachment "B")
- ☐ Completed supervisor's affidavit (Attachment "A")
  Note: An affidavit form is required from each employer
- ☐ Official transcript or diploma verifying graduation from an educational program

FOR: TRAINEE

- ☐ Application fee $50.00
- ☐ Criminal background record check fee $15.00
- ☐ Completed supervisor's affidavit form (Attachment "A")
- ☐ Verification of enrollment in a respiratory care program. As verification of enrollment, the Board will accept the following:
  - A. Notarized copy of certificate of enrollment in an accredited respiratory care program, or
  - B. Original or notarized copies of official letter from the accredited respiratory care program Indicating that the applicant is enrolled at the time of application

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BOARD OF RESPIRATORY CARE PRACTITIONERS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
Direct Tel: (207) 624-8579 Receptionist: (207) 624-8603
FAX: (207) 624-8637 TTY/Hearing Impaired: (207) 624-8563

Office Use Only

Cash # _____

4260 1446 $50
4260 1421 $135/ $67.50
4260 1422 $135/ $67.50
4260 1423 $25
4260 1424 $25
4260 2619 $15

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

Email: cathleen.a.bitz@maine.gov

APPLICATION FORM

Payment of fees may be made in the form of a check or money order payable to Treasurer, State of Maine, VISA or MasterCard – (see credit card authorization form)

PLEASE CHECK APPROPRIATE BOX:

❒ Respiratory Care Technician ❒ Respiratory Care Therapist

❒ Temporary Respiratory Care Technician ❒ Respiratory Care Trainee

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Name:		
Any Other Names Used:		
***Contact Address*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone:***	
Social Security:	***Date of Birth:***	

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EDUCATION

Name of Accredited School: _____

Diploma/Degree Awarded: _____ Date Degree Awarded: _____
Month Year

EMPLOYMENT

Facility	Address	Dates	Position

ALL APPLICANTS MUST ANSWER EVERY QUESTION WITH A YES OR NO, IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER:

Have you ever been credentialed or licensed in another State or Territory including Maine? ❒ Yes ❒ No
If credentialed or licensed in more than one State, please list each state separately. Please use a separate sheet of paper for additional States.

State: _____ Registration # _____ Date Issued: _____Expiration date: _____

State:_____ Registration # _____ Date Issued:_____ Expiration date:_____

State:_____ Registration # _____ Date Issued: _____Expiration date:_____

1. Has any State Board governing the practice of respiratory care denied your application for examination or license? ❒ Yes ❒ No

2. Has your credential or license ever been suspended or revoked by any State? ❒Yes ❒ No

3. Have you ever been convicted of a crime, other than a minor traffic violation? ❒Yes ❒ No
   If yes, please submit copy of the court judgment and decision and a detailed explanation of the crime convicted.

4. Do you now hold any trainee permit or temporary license with the Maine Board of Respiratory Therapist?

   ❒ Yes ❒ No

FOR TRAINEES ONLY

Name of Accredited School: _____

Enrollment Date: _____ Expected Date of Graduation: _____
Month Year

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FOR TEMPORARY TECHNICIANS AND TRAINEES ONLY

Name of Supervisor:	License #:
Printed Name of Supervisor:	
SUPERVISOR MUST BE A PERMANENT LICENSED CARE PRACTITIONER AND MUST COMPLETE THE SUPERVISOR'S AFFIDAVIT FORM. RETURN THIS FORM WITH YOUR APPLICATION	

I AFFIRM UNDER PENALTIES OF PERJURY AND SUBJECT TO THE DISCLIPINARY LAWS AND RULES OF THE BOARD THAT ALL INFORMATION REQUESTED IN THIS APPLICATION FORM HAS BEEN ANSWERED AND THAT ALL ANSWERS ARE ACCURATE AND TRUTHFUL.

PRINTED OR TYPED NAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

DATE: _____

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BOARD OF RESPIRATORY CARE PRACTITIONERS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
Telephone # (207) 624-8579 Fax #: (207) 624-8637
TTY/Hearing Impaired (207) 624-8563

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

SUPERVISOR'S AFFIDAVIT

ATTACHMENT "A"

REQUIRED FOR: (1) Licensure as a temporary technician, or
(2) Registration as a respiratory care trainee

NOTE: To be completed by a Maine Licensed Respiratory Care Practitioner who will supervise this applicant. The completed form must be returned directly to the applicant to be submitted with his/her application.

Name of Applicant:		
Name of Supervisor:		
Supervisor's License #:	Level:	
Facility:	Telephone:	
Address**:**		
City:	State:	Zip Code**:**
Applicant Signature:	Date:	
Printed Signature:		

I hereby certify that the above-named applicant will be under my supervised respiratory care practice from _____ to _____. I understand that the board may request information concerning work performance by the applicant under my supervision, or inspect the "orientation checklist" as specified under 32 M.R.S.A. Section 9707 (for temporary technician license) or section 9707-a (for respiratory care trainee registration).

Supervisor's Signature:	License :
Printed or Typed Name of Supervisor:	Date:

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GOVERNOR

ANNE L. HEAD
DIRECTOR

PROFESSIONAL REFERENCE FORM- Attachment "B

Please Complete This Form and Return Directly to Applicant

Name of Applicant:		
***Contact Address of Applicant*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Social Security #:	***Date of Birth:***	
In what professional capacity do you know the applicant?		
How long have you known the applicant?		
Are you related to the applicant? ☐***Yes*** ☐***No If yes, how?***_____		
Please give a brief statement of your knowledge of the applicant's ethical practice of respiratory care: _____ _____		
Signed:_____ ***Date:***_____		
Printed name:_____ ***Title:***_____		
***Contact Address*:**		
City:	***State:***	***Zip Code:***

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Telephone (207) 624-8579 Fax: (207) 624-8637
TTY/Hearing Impaired: (207) 624-8653

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

VERIFICATION OF LICENSURE
(Attachment "C")

INSTRUCTIONS: The applicant listed below is applying for licensure to practice respiratory care in the State of Maine. The Maine Board of Respiratory Care Practitioners requests written verification from each state where the applicant holds any certification licensure or other credential. This is your authority to release any information in your files, favorable or otherwise.
Please mail this verification directly to the applicant.

This section to be completed by the applicant and forwarded to the board that issued the license.

Name of Applicant:		
***Contact Address of Applicant*:**		
City:	***State:***	***Zip Code:***
License #:	***State:***	***Issue Date:e***
Applicant Signature:		

This section to be completed by the state licensing board where applicant holds or has held licensure and forwarded back to the applicant.

Type of license held by applicant ☐ Therapist ☐ Technician
Is applicant currently licensed? ☐ Yes ☐ No

If not currently licensed, when did license expire?
License #: _____ original issue date: _____

Is the applicant considered a respiratory therapist/technician is good standing in your state?
☐Yes ☐ No if no, please explain:
Has there been any complaints filed against this applicant resulting in disciplinary action taken?
☐Yes ☐No
If yes, please explain?_____

State Officials Signature:	Date:
Printed or Typed Name:	Title:
Name of State Board:	Phone Number:

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PRACTITIONERS
35 STATE HOUSE STATION
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Telephone: (207) 624-8579 Fax: (207) 624-8637
Hearing Impaired: (207) 624-8563

JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Contact Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Name of cardholder: **(if other than applicant)**		
***Contact Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard** **Card number**_____

Expiration date: _____/_____/_____ **in the amount of: $**_____

Signature: _____**Date:** _____/_____/_____.

PHONE: (207)624-8579
(Office Phone)

PRINTED ON RECYCLED PAPER

FAX: (207)624-8637

(207)624-8653 (TTY/HEARING IMPAIRED)

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STATE OF MAINE

STATE BOARD OF RESPIRATORY CARE PRACTITIONERS

APPLICATION FOR ASSOCIATE PERMIT

Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8579
HEARING IMPAIRED (207) 624-8563
Office located at: 122 Northern Avenue, Gardiner, Maine
E-mail: Cathleen.a.bitz@maine.gov

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APPLICATION INSTRUCTIONS

If you are coming from another state and plan to practice in Maine in association with a respiratory care practitioner licensed in Maine for no more than 30 days in a calendar year, you must apply for and receive and Associate permit before you can start working.

Completed applications must be submitted with all of the supporting materials, including fees. Incomplete applications will be returned. Payments may be made in the form of a check payable to Treasurer, State of Maine, VISA, or MasterCard.

If an applicant is licensed in another state the following must be submitted:

- ☐ Application
- ☐ Permit fee $10.00
- ☐ Verification of an active license in good standing from another state that has licensure requirements are equivalent to the requirements of this chapter. (Attachment "A")
- ☐ Verification of being certified or registered by the National Board of Respiratory Care
- ☐ At the time of application, the associate must report all of the dates and locations that the respiratory services will be performed in Maine, which may not exceed 30 days in a calendar year.

If an applicant is certified or registered by the National Board of Respiratory Care and resides in a non-licensure state the following must be submitted:

- ☐ Application.
- ☐ Permit fee $10.00 and $15.00 criminal history record check fee.
- ☐ Verification of being certified or registered by the National Board of Respiratory Care
- ☐ Documentation of being employed as a Respiratory Care Practitioner for at least six (6) months within the immediate three (3) years of the date the Board received the application.
- ☐ At the time of application, the associate must report all of the dates and locations that the respiratory services will be performed in Maine, which may not exceed 30 days in a calendar year.

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35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035
Direct Tel: (207) 624-8579 Receptionist: (207) 624-8603
FAX: (207) 624-8637 TTY/Hearing Impaired: (207) 624-8563

JOHN ELIAS BALDACCI
GOVERNOR

Email: Cathleen.a.bitz@maine.gov

ANNE L. HEAD
DIRECTOR

Notice regarding Social Security Number Disclosure	**Notice regarding Public Information**
The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.	This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Associate Permit Application Form

Applicant Name:		
***Applicant Contact Address*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone:***	
Social Security #:	***Date of Birth:***	
1. Applicant Place of Employment: **Name of Facility**		
***Mailing Address of Facility*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Date of Employment under the associate permit:	***From:***	***To:***
Name of Maine licensed respiratory care practitioner who you will be working with:		
License #:	***Telephone #:***	
2. Applicants Place of Employment:(Name of Facility)		

***Mailing Address of Facility*:**		
City:	***State:***	***Zip Code:***
County:	***Telephone #:***	
Date of Employment under the associate permit	***From:***	***To:***
Name of Maine licensed respiratory care practitioner who you will be working with:		
License #:	***Telephone #:***	

PLEASE ANSWER ALL QUESTIONS WITH A YES OR NO, IF YES, PLEASE PROVIDE A DETAILED EXPLANATION ON A SEPARATE SHEET OF PAPER:

Are you currently or have you ever been credentialed or licensed in another State or Territory?

❒ Yes ❒ No

If credentialed or licensed in more than one State, please list each state separately.
(If you are licensed in additional States, please list on a separate piece of paper)

State: _____ Registration #: _____ Date Issued: _____ Expiration date: _____

State: _____ Registration #: _____ Date Issued: _____ Expiration date: _____

Has any State Board governing the practice of respiratory care denied your application for examination or license? ❒Yes ❒ No

Has your credentials or license ever been suspended or revoked by any State? ❒ Yes ❒ No

Have you ever been convicted of a crime, other than a minor traffic violation? ❒ Yes ❒ No

If yes, please submit copy of the court judgment and decision and a detailed explanation of the crime convicted.

Signature of Applicant: _____ Date: _____

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35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

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GOVERNOR

ANNE L. HEAD
DIRECTOR

VERIFICATION OF LICENSURE
(Attachment "A")

INSTRUCTIONS: the applicant listed below is applying for licensure to practice respiratory care in the State of Maine. The Maine Board of Respiratory Care Practitioners requests written verification from each state where the applicant holds any certification licensure or other credentials. This is your authority to release any information in your files, favorable or otherwise**.** ***Please mail this verification directly to the applicant.***

THIS SECTION TO BE COMPLETED BY THE APPLICANT AND FORWARDED TO THE BOARD THAT ISSUED THE LICENSE.

Name of Applicant:		
***Contact Address of Applicant*:**		
City:	***State:***	***Zip Code:***
License #	***State:***	***Issue Date:***
Applicant Signature:_____		

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THIS SECTION TO BE COMPLETED BY THE STATE LICENSING BOARD WHERE APPLICANT HOLDS OR HAS HELD LICENSURE AND FORWARDED BACK TO THE APPLICANT.

Type of license held by applicant ☐ Therapist ☐ Technician

Is applicant currently licensed? ☐ Yes ☐ No

If not currently licensed, when did license expire?

License #: _____ Original issue date: _____

Is the applicant considered a respiratory therapist/technician in good standing in your state?
☐ Yes ☐ No

If no, please explain:

Has there been any complaints filed against this applicant resulting in disciplinary action taken?
☐ Yes ☐ No

If yes, please explain: _____

State Official Signature:
Date:
Printed Name:
Title:
Name or Phone Number of State Board:

BOARD SEAL

PHONE: (207)624-8579
(Office Phone)

PRINTED ON RECYCLED PAPER

(207)624-8653 (TTY/HEARING IMPAIRED)

FAX: (207)624-8637

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JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: **(applicant fees being paid for)**		
***Contact Address*:** **(applicant fees being paid for)**		
City:	***State:***	***Zip Code:***
County:	***Telephone:***	
Name of cardholder: **(if other than applicant)**		
***Contact Address*:** **(if other than applicant)**		
City:	***State:***	***Zip Code:***

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ **Visa** ☐ **MasterCard**_____

Card number

Expiration date: _____/_____/_____ **in the amount of: $**_____

Signature: _____**Date:** _____/_____/_____

PHONE: (207)624-8579
(Office Phone)

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